Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CROWN CHIROPRACTIC
2401 N ARKANSAS
LAREDO TX 78043

Carrier's Austin Representative Box

Box Number 19

Respondent Name

NATIONAL UNION FIRE INS CO OF PITTSBURG PA

MFDR Date Received

February 27, 2012

MFDR Tracking Number

M4-12-2227-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a bill for certification of MMI/IR which is compensable as per the RULES…suffered an injury to the lumbar spine. Base pay for DRE is $500.00 which is what was done. This case represents $500.00 which should be payable. The carrier has paid $350.00 and will not pay additional amount after reconsideration using a rational of FEE SCHEDULE ADJUSTMENT. I contest that the carrier owes the additional $150.00."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute for consideration.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2011	CPT Code 99456-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 7, 2012
   - 1 – (W1) Workers Compensation State Fee Schedule Adjustment.
   - 1 – No Reduction Available. (VRNA)
   - 2 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

   Explanation of benefits dated February 14, 2012
   - 1 – (W1) Workers Compensation State Fee Schedule Adjustment.
   - 1 – No Reduction Available. (VRNA)
   - 2 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - * – Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution. (X394)

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $500.00 for CPT code 99456-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00.

   To determine reimbursement for an IR, the method of calculating IR and the number of body area/conditions are reviewed. Review of the narrative documentation submitted supports the rating of the lumbar spine (spine) using the Range of Motion method per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I)(a)). Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00.

   The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-WP is $650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the disputed amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 6, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.